Mental Health/Alcohol and Other Drug Abuse Managed Care

Frequently Asked Questions

This frequently asked questions (FAQ) document represents the Department of Health and Family Services' thinking on a number of issues related to mental health and alcohol and other drug abuse (MH/AODA) managed care. By design, the FAQ is a work in progress and, as such, is meant to stimulate comment, discussion and additional questions. We will continue to revise the document and add to it as our work progresses and use this as a means to communicate policy decisions to persons interested in this initiative. You may forward comments to:

Shel Gross, MH/AODA Managed Care Policy Analyst
Bureau of Health Care Financing, Room 237
P.O. Box 309
Madison, WI 53701-0309

Phone: 608-266-8473
Fax: 608-261-7792
Email: grosss@dhfs.state.wi.us

1. Why are we proposing MH/AODA managed care demonstrations?

The following are our main goals:

- Implement the principles outlined in the final report of the Governor's Blue Ribbon Commission on Mental Health (BRC).
- Incorporate the concept of recovery into the system of care.
- Increase the emphasis on prevention and early intervention.
- Increase consumer, family, and advocate involvement at all levels of system decision-making, service delivery and evaluation.
- Integrate federal, state and local funding for MH and AODA services to create a comprehensive and very flexible system of care. Currently, the rules that accompany some funding, especially Medicaid, make it difficult to provide individuals with the services they might need and want, when and where they need them.
- Use managed care techniques to improve the quality of care, outcomes of care, accountability for care and realize a reduced rate of growth in expenditures for the state and counties.
- Better integrate or coordinate a person's physical health care needs with his or her MH or AODA treatment needs.
- Minimize the differences in access and availability of services to the target populations that currently exist across the state.

Some of these goals will be accomplished by enrolling individuals in prepaid managed care programs (e.g., integration of funding). Other goals, such as implementing the BRC principles and emphasizing prevention and early intervention, may be accomplished both within the prepaid managed care programs and also through related efforts undertaken by the Department in collaboration with counties, providers, consumers and families.

2. How is this managed care system different from the current system of care?

Currently people with serious mental illness and alcohol and other drug abuse treatment needs receive services that are paid for by different payers. The primary public funds come from Medicaid, federal block grant dollars, state dollars that counties administer, and county tax levy. These different payers may have different services they will cover, different rules about what will be approved and different requirements for the use of the funds. As a result people may not get the type of interventions they need if the payment source does not allow the type of intervention they need.

Through managed care we hope to blend these four primary payment sources. Through our contracts we will provide more flexibility to the managed care organization in the services they may provide, but we will also place more emphasis on measuring the outcomes of these interventions. We will define common assessment and service coordination requirements and quality assurance mechanisms. Because the managed care organizations will share some risk for the cost of services, they will have an incentive to be efficient in how they achieve their outcomes. Our goal is a system that is focused on achieving desired outcomes for people in flexible ways that maximize consumer choice rather than providing a select set of "covered services" that may or may not be what people need or want.

3. Who is going to decide how all this will work?

The Department is currently in the midst of a broad planning process under the auspices of the Department's Long-Term Care Redesign process. This effort is advised by the Blue Ribbon Commission Implementation Advisory Committee (BRC-IAC), appointed by Sec. Leean. The BRC-IAC consists of county representatives, consumers, family members, legislators and providers of both mental health and AODA services. To help us develop the specifics of the demonstrations, the Department selected a group of representative counties through a competitive application process. These counties have brought teams of county staff, providers, consumers and family members to work with us in a number of planning groups. These planning groups will make recommendations on various issues related to the organization of the system of care: screening and enrollment requirements, care planning requirements, who should be eligible for enrollment, etc. Many of the answers in this document are the result of the initial efforts of these planning groups.

The Department is also benefiting from what we have learned through the long-term care redesign planning process. Some issues, like how counties can assume risk, overlap to a great degree and don't need to be reinvented. Also, the Department has convened workgroups related to implementation of the Blue Ribbon Commission report recommendations. We are coordinating with these groups as well. Finally, we are utilizing ideas from other Medicaid managed care programs for special populations, both here in Wisconsin and in other states.

4. Who will be eligible to be enrolled in the MH/AODA managed care demonstrations?

Mental Health:

- Enrollment in the prepaid managed care portion of the demonstrations will be limited to target populations 1 and 2 as defined by the BRC: persons in need of ongoing, high-intensity or low-intensity comprehensive services.

- BRC target population 3, persons in need of short-term situational services, will be served through the demonstration projects, but at least initially not through prepaid managed care. The planning groups will be exploring how to incorporate BRC principles in how we respond to situational crises.
- Similarly, prevention activities aimed at BRC target populations 4 and 5, persons at risk and persons at acceptable levels of mental health, will not be part of prepaid managed care. The planning groups will address how to address these activities within the demonstration projects.

AODA: There are a number of levels of potential eligibility related to AODA.

- Persons who are eligible because of co-occurring mental illness and AODA problems will receive any necessary AODA services, including Medicaid AODA services, through the prepaid managed care system.
- If the State is able to receive a waiver from the federal government, we will consider expanding Medicaid eligibility to include individuals who are in intermediate to late stages of alcohol or other drug abuse and include these people in the managed care system. These are people who frequently use detoxification services, live in halfway houses or may be homeless, and have considerable deficits in independent living skills.
- Counties/tribes will have an option to propose that other groups of Medicaid recipients will receive their AODA services in the managed care portion of the demonstrations. These groups may include children in foster care, the elderly, and individuals exempted from the AFDC-HMO initiative.
- We will explore our ability to include funds or services that are, by statute, targeted to specific, limited populations, such as intravenous drug users, persons with HIV, or intoxicated driver program services.

5. The BRC addressed mental health only. How come we're now talking about including people with alcohol and drug abuse disorders?

The Department's original concept paper on MH/AODA managed care was inclusive of both mental health and AODA. Released in April 1996, the concept paper provided the broad outlines of the system we are now trying to develop.

The effort to organize a Blue Ribbon Commission on Mental Health had been underway for quite some time when the concept paper was released and the Commission was convened in May 1996. Through its charge the Commission was limited to developing a design for the mental health system only, although the Commission recognized that major changes in the mental health system would necessitate corresponding changes in AODA. Once the Commission completed its work and its final report was accepted by the Governor, the Department formed the BRC-IAC, which also included AODA representation, to help oversee the development of the managed care demonstrations.

As planning has progressed, the planning groups have started to examine in more detail the implications of combining mental health and AODA populations and services. The subgroup working on AODA issues has also examined how the vision and principles outlined in the BRC final report do and do not "fit" for AODA. A revised vision/mission statement that covers both mental health and AODA has been drafted and approved by the BRC-IAC.

6. Will eligibility be limited to people who are on Medicaid because of Supplemental Security Income (SSI)?

No. While many of the individuals who fall into the target population will be on SSI, others may be on Medicaid for other reasons (such as children in foster care or the elderly) and still others will be uninsured or underinsured. This latter group is currently served through the county system of care and supported by funds other than Medicaid. We envision that the managed care demonstrations will combine the Medicaid and non-Medicaid populations. Eligibility will be based on the person's level of functioning, not on diagnosis or payment source.

7. What about people eligible for both Medicaid and Medicare?

People eligible for both Medicaid and Medicare, often referred to as "dual eligibles", will be eligible to be part of the prepaid managed care. However, it is very difficult to develop capitated *Medicare* programs, so that the managed care organization will need to have the ability to bill Medicare on a fee-for-service basis for any Medicare-covered services until such time as a Medicare waiver is obtained. The Medicaid capitation rate is generally lower for these individuals since Medicare is the primary payer for services.

8. Will people with both a mental illness or alcohol and other drug abuse disorder and physical disability, developmental disability or infirmities of aging be part of this initiative or Family Care?

Family Care, the Department's redesign of the long-term care system, will serve people whose functional deficits are primarily due to a physical disability, developmental disability or infirmities of aging. Family Care is not designed to serve people whose primary functional impairments are due to a major mental illness or AODA disorder. However, the Department recognizes that there is a group of individuals who will have both types of conditions. We are exploring the options for addressing the needs of this group.

9. Will this program be an entitlement for the persons eligible to enroll?

Under federal regulations, Medicaid recipients have an entitlement to Medicaid-covered services. They will retain this entitlement, either by receiving these services through the managed care system or in the current fee-for-service system.

Under state statutes, counties have the responsibility to provide services to persons with mental illness and substance abuse disorders. While persons with serious disorders have always been a priority for the counties, individuals do not have an entitlement to services through the counties. Counties are limited in their liability to provide services to the amount of funds provided by the State and the county matching funds required in receipt of these funds.

We hope to create a system where people who meet a certain level of functional disability will be entitled to services. Some people with assets and income may be expected to pay a portion of the costs through a cost-sharing arrangement.

10. Will people in the target populations be required to enroll in the managed care organizations?

We have not made a final decision about this. The planning group generally favored a mandatory enrollment, as long as there is some way for persons to disenroll with good cause. The planning group felt that to a large degree the county system is already a mandatory system for persons with serious mental illness—in many areas of the state there are not private providers who will serve this population except through contracts with the county. One concern expressed by consumers was the ability to see a psychiatrist of their choice.

Counties were not unanimous in their preference, but most prefer a mandatory system. In a mandatory system, the managed care organization has more certainty about the number of people that they will need to serve and the amount of money they will have available. Another consideration is that in a voluntary program, the county will need to operate two systems—the current fee-for-service system and the managed care system. This is much less efficient.

In a large part, our decision depends upon our discussions with the Health Care Financing Administration (HCFA), the agency that oversees Medicaid at the federal level. We have started regular discussions with HCFA and will be addressing this, as well as other issues. HCFA has stated that if we wish to mandatorily enroll individuals to the county as the sole provider of services we need to do one of two things:

- Have the county selected through a competitive procurement process that would be open to private organizations, or
- Request an exemption from the federal competitive procurement requirements.

11. Counties submitted different proposals about the populations that they would include in their demonstrations. Are you saying now that all the demonstration projects must be the same?

At this point, we want to establish common requirements for the level of severity of functioning that makes someone eligible for the prepaid managed care portion of the demonstration. We will also establish common requirements for cost sharing, care planning, use of consumer-operated programs, outcome measurement, quality assurance and other program features. However, when we accept applications for the actual demonstration projects we envision that counties/tribes will have flexibility, at least, in the following areas as they begin the managed care demonstrations:

- which age groups they want to include (children/adolescents, adults, elderly),
- whether to limit the Medicaid enrollees to the SSI group or include other Medicaid populations (e.g., foster care),
- whether they will include primary and acute care in their proposals, and
- whether they will be the managed care organization or contract for this function.

However, eventually we want to see people of all ages who meet the functional eligibility criteria be covered through this system.

12. Which dollars will be included in the prepaid managed care payments?

Our goal is to include all dollars currently being used to serve the populations identified in #4, above. We plan to identify these dollars through the following process.

First we will work with our county partners to identify a sample of actual individuals who fall into the target population. For Medicaid, we will have the Medicaid actuaries calculate the amount Medicaid would pay for the covered services for the target population based on three years worth of fee-for-service claims data. This will be the basis of the Medicaid payments to the managed care organizations.

In most cases, counties do not track community aids or tax levy dollars to individuals. Allocations are generally made to programs. Our goal is to work with counties to better determine the amount of locally administered dollars that provide services to the target population. We anticipate that we will request counties to identify and justify their contribution of community aids and tax levy dollars as part of their proposal to become a demonstration site. We believe this baseline information is necessary so that we can determine whether the system is, in fact, reducing the rate of growth and also to measure whether either State or county funds are supplanting the other. If the county is going to contract with another organization to provide the managed care services, we will work with the counties to determine an appropriate payment rate.

13. It sounds like the Department does not intend to capitate community aids or the county share for the demonstrations. What about further in the future?

It is correct that the Department does not intend to capitate community aids or the county share for the early demonstration phase. However, as noted above, we do want to establish a benchmark for the county contribution of community aids and collect better information on spending by revenue source during the demonstrations.

The Department is interested in using information gained during the demonstrations to determine whether and how best to capitate community aids at the state level and how best to determine the county share in the future. Once we identify and capitate the portion of community aids serving target populations 1 and 2, we can move towards making this an entitlement for the target populations.

14. Will the capitation payment in the demonstration, then, be only for the Medicaid eligible individuals?

Yes. The current thinking is that the Medicaid capitation would be made to the county. The county could then utilize these funds flexibly, along with the community aids and tax levy they now administer.

15. Will there be one capitation rate for all the demonstrations, or different rates for different sites? Similarly, will there be one rate for all enrollees, or different rates depending upon the level of individual's need?

The answers to these questions will depend upon the actuarial analysis of the Medicaid claims data. When we send the claims data to the actuaries, we will also include information about county of residence and severity of need. The severity of need information will be based on a variety of sources, including the Human Services Reporting System and the judgement of staff from our planning partner counties. When the actuaries analyze this information they will be able to tell us whether site specific rates are appropriate and whether any of our methods for identifying severity of need clearly sorts individuals into "rate bands".

If, in fact, the data suggests that we have the ability to identify people into categories that reasonably predict future costs, we will still need to decide if we want to do this or not. There are

some potential problems with doing this. For instance, what if an individual has needs that fluctuate over time or what if an individual improves so their level of need declines? Will we be able to identify a way to move them into a more appropriate rate band when these changes occur? Our planning group will address these issues once we receive the analysis from the actuaries.

16. Will the MCO need to meet the same requirements for non-Medicaid individuals as for Medicaid eligibles?

The Department must assure compliance with federal Medicaid regulations for the Medicaid enrollees. Because we want a system that ensures a minimum level of quality for all enrollees, we will have the planning groups review whether the MCO should meet the same requirements for all enrollees. The Department would prefer a single set of requirements for all enrollees, Medicaid or non-Medicaid, unless we determined that the additional federal requirements would be burdensome to implement for the non-Medicaid enrollees without adding to the quality of care.

We anticipate that the MCO will need to meet all applicable state requirements governing mental health and AODA for all enrollees—both Medicaid and non-Medicaid. However, we will also ask our planning group to recommend whether we should waive portions of any current state standards for the demonstration projects. We would only want to do this if these portions of the standards are impediments to implementing the goals of the demonstration projects and the objective of the standard can be accomplished in some other manner. The rationale for this is that we want to move to a system that purchases outcomes, rather than processes. In the absence of carefully defined measurable outcomes, current standards define minimum program requirements in terms of processes or inputs. As we improve our ability to monitor and measure outcomes, we want to give MCOs more flexibility in how they achieve these outcomes. This will allow MCOs the ability to use lower cost personnel, when appropriate, and creative, flexible approaches in meeting enrollee needs.

17. Can the Medicaid dollars in the capitation payment be spent on Medicaid recipients only or for Medicaid covered services only?

The MCO must be able to make available any Medicaid-covered services specifically identified in the contract. However, if the MCO is able to achieve savings by better care management, substitution of lower cost services, etc., the savings may be used in any way not prohibited by the contract. This would mean that these savings could be used for non-covered Medicaid services as alternatives to Medicaid-covered services unless the contract specifically states otherwise.

18. Isn't there a possibility that more people will demand services under managed care?

To the degree that some people have been inadequately served under the current system, we hope that more people will be served under managed care. Improved access, as well as accountability to provide services is one of the goals of the redesign, as noted above. We anticipate that the managed care organizations will manage this demand through some combination of the techniques described in #19, below.

19. Where will the money come from to serve more people?

We believe that there are many ways the dollars currently in the system can go further:

- *Substitution of services*. To the degree that money is being spent on expensive institutional care, persons may be served in the community at less cost with the flexibility allowed under managed care.
- *Consumer-operated services*. This is another type of substitution of services. Some services now provided by professionals may be better provided through consumer-operated programs. Not only could this reduce costs, but it would also support the recovery goals of the consumers helping themselves and each other.
- *Substitution of personnel*. Services currently provided by higher cost personnel may be provided appropriately by lower cost personnel, but under the FFS system the provider has an incentive to use the higher cost person in order to receive more reimbursement.
- *Recovery*. While the concept of recovery does not imply a "cure" for individuals, it does create a system where hope for a better future permeates all actions and results in the firm belief that people can achieve maximum independence from the formal system of care. Recovery assumes that people will live their life to their fullest potential despite their mental illness or substance abuse disorder. As people use fewer services, increasingly rely on peers and natural supports, or function more independently, this provides long-term savings to the system of care.
- *Improved treatment*. Use of state-of-the-art treatment protocols, medications and services will make service provision more efficient and achieve better outcomes.
- *Focus on prevention and early intervention*. Prevention and early intervention activities with persons at risk can reduce the need for more expensive treatment services. Disorders targeted by the BRC for prevention and early intervention are depression, conduct disorders and post traumatic stress disorder.
- *Improved management techniques*. Efficiency can be improved by importing management techniques from existing managed care programs. These include integrated management information systems that provide "real-time" information on utilization and expenditures; utilization management and provider profiling; and changes in contracting with provider networks.

20. Is there a chance that people who are receiving services now may not receive the same level of services in the future?

While we believe that managed care offers opportunities to improve and expand services, we cannot assume that everyone receiving services now will receive the same level of service in the future. Because we want to move to a performance-based system of care, we are less concerned about whether people receive the same level or type of services as in the past as we are about the outcomes of services provided. We are firmly committed to developing a better system, not one that leaves people worse off. We will carefully monitor the transition from the "old" system to the "new" system to ensure this. A key component of the managed care contracts will be quality assurance and measurement of outcomes.

We envision consumers and families having an important and substantive role at the state and local level, participating in management and oversight of the managed care system. We believe that people at the local level will be in the best position to identify whether managed care is realizing its potential. The planning groups will be asked to recommend contract language that will ensure that people acting in oversight capacity have the authority to address problems if they occur.

Our consumer outcomes workgroup has been meeting since December 1997, and is developing a survey that will allow us to find out directly from consumers how the system is working. The group will also be recommending measurement tools that will allow us to identify whether individuals are functioning better as a result of the services they receive from the managed care system.

21. Will "mental health" dollars be spent on persons with alcohol and other drug abuse?

We know that many people with serious mental illness also have alcohol and drug abuse treatment needs. As noted above, our goal is to identify the amount of funds that have been utilized in the past for persons in the target populations. This will include dollars that were used to provide both mental health and AODA services to this population. The money that is spent on each individual under managed care will depend upon an individualized care plan which will be based on a comprehensive assessment of the person's needs and the person's service preferences. In such a system, either more dollars or fewer dollars could be spent on "mental health" services, depending upon the needs and preferences of the individuals. We expect more dollars to be spent on non-traditional services that are recommended by the treatment team based on a comprehensive assessment and that may not be readily classified as either mental health or AODA.

We recognize that people with co-occurring disorders may not have been well served in the past. Both the mental health and AODA treatment systems could benefit from additional dollars. We hope that efficiencies achieved through managed care will allow more people—with mental illness, substance abuse disorders or both—to get the services they need. As noted above, we do not want this to happen at the expense of people currently receiving services.

Because concerns exist about how funds will be utilized we are placing special emphasis on reporting requirements. One goal of the demonstrations is to more clearly define how dollars are spent, and in the case of locally administered dollars, understand more clearly the source of funds. The demonstration projects are a research opportunity to better understand these issues

22. Will the managed care organization be at risk if it cannot save enough money through these mechanisms to serve additional people?

During the transition to managed care the Department intends to share risk with counties and managed care organizations (if the MCO is not the county). While we have not addressed this issue in detail during the MH/AODA managed care planning, the Department has addressed this in considerable detail for Long-Term Care Redesign. There are, in fact, many ways that counties can manage their risk successfully. To the degree that counties will be the MCO, the issues around risk will be very similar and the Department would like to address them similarly in the two initiatives. We anticipate that there may be some differences in those demonstrations that wish to provide integrated MH/AODA and primary and acute care. Interested persons should check the Department's website at www.dhfs.state.wi.us and click on "Programs" and then "Long Term Care Redesign" or contact Mary Rowin at 608-261-8885 for more information.

23. Can the managed care organization have waiting lists?

When someone is enrolled in an MCO, they may not be put on a waiting list for services. We will require that the MCO have adequate providers to meet the service needs of its enrolled population. However, managed care contracts generally allow the MCO to establish a limit on the

number of people that they will enroll at any one time, and we anticipate that this will be the case in the demonstrations. While our long-term goal is to have all individuals in the eligible populations described above included in prepaid managed care programs (either mandatorily or by their choice), it may not be feasible for the MCOs to develop capacity to achieve this goal during the first year or two. Enrollment limits allow MCOs to develop their service networks in an orderly manner to serve the people they do enroll.

Because increased access to services is an important goal of the demonstrations, our evaluation will look at whether this is occurring. It is not the Department's intention to allow MCOs to use enrollment limits as a way of limiting enrollment to only the individuals currently being served by the MH/AODA system.

While the MCO cannot have a waiting list, it can establish reasonable time limits for providing services. We anticipate having contract language that defines the outside limits of how long individuals will need to wait to receive emergency, urgent or routine services.

As mentioned earlier, emergency services to individuals not already enrolled in the prepaid managed care program will be a separate issue. We will have mechanisms to address emergency services for these people as part of the demonstration project.

24. If MCOs can limit their enrollment, how do we know they won't discriminate in whom they do admit?

Both the Department and HCFA are concerned about this issue. We want to make sure that any person who meets the eligibility criteria has an equal chance to enroll in the managed care program, up to the enrollment limit. The planning group is developing a screening tool to determine eligible enrollees. However, since no screening tool is totally objective we will develop policies about who should administer the screen and how the state should oversee this process.

25. How will court-ordered services be handled?

All current Department contracts for Medicaid managed care require the managed care organization to provide and pay for court-ordered services if they are services covered under the contract. The contracts provide some limitations to this general policy. For example, in the current Medicaid health maintenance organization (HMO) contracts the HMO is not required to pay for the service when the court orders a provider outside the HMOs provider network and the HMO could have provided the service through its provider network. Some contracts have also allowed the HMO to request a disenrollment if the court order is not consistent with the plan of care developed by the treatment team. We have encouraged the current HMOs to work closely with the county and the courts to ensure appropriate and timely services for this population. We envision comparable language in our contracts for MH/AODA managed care.

To the degree that court-ordered services have been billed to Medicaid, these costs will be incorporated in the Medicaid capitation rate. To the degree that counties have paid for these services, and we identify these costs as part of the county share, these dollars will be incorporated into the demonstration project. Because crisis intervention has been added as a Medicaid benefit, it should be possible to adjust the Medicaid capitation rate to reflect the ability of counties to bill for this new service.

For individuals not enrolled in the prepaid managed care portion of the demonstrations, court-ordered services will be handled as they are now. Counties will have responsibility for ensuring

the court order is carried out. To the extent that Medicaid or other health insurers cover the cost of the services, the insurer may be billed. Otherwise, the county will be responsible for the cost of the services.

26. The demonstration project will include more than the prepaid managed care portion. What will the rest of the demonstration project look like?

Family Care is currently piloting "resource centers" for long-term care clients. These resource centers are responsible for information and assistance, prevention and early intervention and possibly for identifying eligible individuals for the Family Care benefit. Our planning group is currently exploring a similar model for the MH/AODA demonstrations.

We will be further exploring how we can develop a model that is compatible with the long-term care resource centers, so that counties or tribes can integrate these at a local level. We also need to further explore funding issues, since these functions are currently funded primarily through county administered dollars.